



The Right to Die Movement: From Quinlan to Schiavo

Citation

The Right to Die Movement: From Quinlan to Schiavo (2005 Third Year Paper)

Permanent link

<http://nrs.harvard.edu/urn-3:HUL.InstRepos:8889450>

Terms of Use

This article was downloaded from Harvard University's DASH repository, and is made available under the terms and conditions applicable to Other Posted Material, as set forth at <http://nrs.harvard.edu/urn-3:HUL.InstRepos:dash.current.terms-of-use#LAA>

Share Your Story

The Harvard community has made this article openly available.
Please share how this access benefits you. [Submit a story](#).

[Accessibility](#)

Microsoft Word 10.0.6612;

The Right to Die Movement: From *Quinlan* to *Schiavo*

By Anthony Lim

Class of 2005

May 2005

Written under the guidance of Professor Peter Barton Hutt.
Submitted in satisfaction of the class and 3L paper requirements

ABSTRACT

This paper traces the evolution of the right to die movement from its beginnings in 1976 all the way to the present. Part I looks at the beginnings of the movement, focusing on the *Quinlan* and *Cruzan* cases that together helped to establish the right of an individual to refuse life-sustaining medical treatment. Part II discusses the shift in the movement's focus during the Nineties to the highly controversial topic of physician-assisted suicide ("PAS"). Part III explores the events leading up to the Supreme Court's 1997 rulings on the constitutionality of PAS. Finally, Part IV examines the recent Schiavo controversy and the implications that it holds for the future of the right to die movement.

TABLE OF CONTENTS

Introduction.....	4
I. Early Beginnings: The Right to Withdraw Life-Sustaining-	
Treatment.....	6
A. In re Quinlan (1976).....	..6
B. Cruzan v. Missouri, Department of Health (1990).....	14
II. The Next Frontier: Physician-Assisted Suicide.....18
A. Doctor Kevorkian.....	..19
B. Doctor Quill..	...22
C. The Oregon Death With Dignity Act (“DWDA”)26
III. Physician-Assisted Suicide in the Federal Courts.....	..34
A. Ninth Circuit.....35
B. Second Circuit.....37
C. The Supreme Court.....39
IV. The Schiavo Controversy46
A. Background.....46
B. The Florida Legislature Intervenes.....	48
C. Congress Intervenes.....	51
Conclusion.....	...54

Introduction

Prior to the 1950s, physicians practiced without the benefit of modern medicine. They did not have the capability to extend appreciably the lives of terminally ill patients. Most people died in the comfort of their homes without intrusive medical treatment or technology. There was no such notion of a “right to die.”¹

Following World War II, however, the United States experienced growing prosperity accompanied by a technological explosion in many areas, not least of which was medicine. Some of the new developments, just to name a few, included intravenous feeding, new drugs to fight infection, cardiopulmonary bypass machines, coronary angiography for open heart surgery, ventilators, cardiac resuscitation, and kidney dialysis.² Accompanying this wave of new technology was the “technological imperative” – the belief by physicians and hospitals that they should use all available means of medical treatment and technology to try to improve the health outcomes of their patients.³

It was largely as a response to the rapid advancement in medical technology and the technological imperative that the concept of a “right to die” – or the refusal of medical treatment towards the end of life – was born in the 1970s. This paper examines the evolution of the right to die movement from its beginnings in the 1970s all the way to the present. Part I will look at the initial rise of the right to die movement from *Quinlan* through *Cruzan*, and how the movement succeeded in establishing an individual’s constitutional right to withdraw life-sustaining care. Part II will discuss the factors that caused the right to die movement to shift its attention to physician-assisted suicide, the next frontier, and some of the early successes it had in this

¹DEREK HUMPHRY & MARY CLEMENT, FREEDOM TO DIE 15 (1998) [hereinafter HUMPHRY].

²*Id.* at 16.

³*Id.* at 18.

highly controversial area. Part III will examine in detail a critical turning point in the right to die debate, and how what almost came to be a constitutional right to assisted suicide was ultimately rejected by the Supreme Court, though with potential “open doors” for future litigation. Finally, Part VI will discuss the recent Schiavo controversy and its impact on the right to die movement.

I. Early Beginnings: The Right to Withdraw Life-Sustaining Treatment

A. In re Quinlan⁴

The *Karen Quinlan* case, decided in 1976, marked the beginning of the right to die movement.⁵ Prior to the case, very few courts had handed down decisions dealing with an individual's right to refuse life-sustaining treatment,⁶ and those that did were generally very reluctant to permit patients to refuse such treatment.⁷ Most of these earlier cases involved patients who refused medical treatment because of their religious beliefs, thereby implicating First Amendment rights and common-law rights of self-determination.⁸ *Quinlan*, however, was hugely significant in part because it was the first state high court decision to permit a refusal of life-sustaining treatment based upon the Fourteenth Amendment right of privacy.⁹ It was also unique because the facts of the case made clear to the courts what had long been known in the medical profession – namely, that medical technology increasingly enabled physicians to keep patients alive without any restoration of health.¹⁰

⁴In re Quinlan, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

⁵HUMPHRY, *supra* note 1, at 5-6.

⁶*Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 270 (1990).

⁷ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* § 2.01 (3d ed. 2004) [hereinafter MEISEL].

⁸*Cruzan*, 497 U.S. at 270.

⁹HUMPHRY, *supra* note 1, at 82.

¹⁰MEISEL, *supra* note 7, at § 2.01. An important consideration underlying the *Quinlan* case was the changing nature of medical technology and its impact on how death was conceived by the medical profession. In the past, the determination of the fact and time of death was based on the action of the heart and blood circulation, in addition to pulmonary activity – cessation of these functions equated to death. *Quinlan*, 355 A.2d at 656. However, modern resuscitative and supportive measures that can now restore “life” according to ancient standards of persistent respiration and continuing heart beat have challenged traditional indicators of death. An individual could be kept “alive” with cardiopulmonary machines, and yet lack any and all brain function.

The Harvard Committee redefined death in 1968 to be equated with “brain death,” the point at which the following symptoms are observed consistently within a 24-hour period: absence of response to pain or other stimuli, papillary reflexes, corneal, pharyngeal and other reflexes, blood pressure, spontaneous respiration, in addition to “flat” electroencephalograms. *Ibid.* If a patient was diagnosed as brain dead, the general thought within the medical community was that the physician-in-charge, in consultation with any other involved physicians, should be the one to decide to take the patient off the respirator, not the family. *Ibid.*

On the evening of April 15, 1975, for reasons still unclear, Karen Quinlan ceased breathing for two fifteen-minute periods.¹¹ The lack of oxygen to her brain, and resulting severe brain damage, caused her to enter into a “persistent vegetative state,” in which a person is capable of maintaining the vegetative parts of neurological function but no longer has any cognitive function.¹² Although she had no awareness of anything or anyone around her, she was not brain dead because she still possessed vegetative function and demonstrated primitive reflexes.¹³ Karen required a respirator to assist her breathing and a nasogastric feeding tube for nourishment, both of which were deemed necessary by her physician team for her continued survival.¹⁴ No form of treatment that could improve her condition was available, and her physicians predicted that her cognitive function would never be restored.¹⁵

Eventually Karen’s father, Joseph Quinlan, in agreement with other family members, requested the withdrawal of Karen’s respirator. However, Dr. Morse, Karen’s physician, refused the request. He asserted that Karen was not brain dead, and that to take her off the respirator, knowing it would lead to her eventual death, would be a violation of medical standards, practice, and ethics.¹⁶ In response, Mr. Quinlan took his case to the courts, arguing that by virtue of the constitutional rights of privacy, of free exercise of religious belief, and of freedom from cruel and unusual punishment, he should be authorized to withdraw Karen’s life-sustaining mechanisms, and be appointed as her guardian to that end.¹⁷ His request was opposed by

¹¹*Quinlan*, 355 A.2d at 653-54. Some surmise that Karen’s consumption of alcohol that evening in conjunction with a starvation diet that she was on were what caused her to stop breathing for the two fifteen-minute periods. HUMPHRY, *supra* note 1, at 84.

¹²*Quinlan*, 355 A.2d at 654.

¹³*Ibid.* Brain function is divided into two categories – vegetative and cognitive. Vegetative regulation controls basic bodily functions that include body temperature, breathing, blood pressure, heart rate, chewing, swallowing, and sleeping and waking. Cognitive function, in contrast, relates to the more highly developed part of our brain that is uniquely human. It controls our interactions with the outside world and our abilities to talk, see, feel, sing, and think. In order to be declared brain dead, an individual must lack both vegetative and cognitive functionality. An individual who possesses some vegetative functionality but no cognitive functionality would therefore not be considered brain dead. *Quinlan*, 355 A.2d at 656.

¹⁴*Quinlan*, 355 A.2d at 654.

¹⁵*Id.* at 655.

¹⁶*Id.* at 656-57.

¹⁷*Id.* at 653.

Karen's doctors, the hospital, the Morris County Prosecutor, and the State of New Jersey, and was ultimately denied by the trial court.¹⁸ The case came up on appeal to the New Jersey Supreme Court.

The New Jersey Supreme Court rejected Mr. Quinlan's First Amendment free exercise and Eighth Amendment cruel and unusual punishment claims. Regarding the former, the court reasoned from prior cases that the strong governmental interest in preserving life so far outweighed Karen's religious free exercise rights that the case did not trigger a constitutional question in this regard:

The right to religious beliefs is absolute but conduct in pursuance thereof is not wholly immune from governmental restraint. So it is that, for the sake of life, courts sometimes order blood transfusions for Jehovah's witnesses; forbid exposure to death from handling virulent snakes or ingesting poison (interfering with deeply held religious sentiments in such regard); and protect the public health as in the case of compulsory vaccination (over the strongest of religious objections). The public interest is thus considered paramount, without essential dissolution of respect for religious beliefs.

We think, without further examples, that ranged against the State's interest in the preservation of life, the impingement of [Karen's] religious belief... does not reflect a constitutional question.¹⁹

The court additionally found that the Eighth Amendment prohibition of cruel and unusual punishment applies only to situations that involve the imposition of penal sanctions, and therefore was inapplicable to the case at hand: "Neither the State, nor the law, but the accident of fate and nature, has inflicted upon her conditions which though in essence cruel and most unusual, yet do not amount to 'punishment' in any constitutional sense."²⁰

¹⁸In re Quinlan, 348 A.2d 801 (N.J. Super. Ct. Ch. Div. 1975).

²⁰*Id.* at 662.

However, after rejecting the applicability of the First and Eighth Amendments to the case at hand, the court looked to two recent Supreme Court decisions before reaching the momentous conclusion that an individual's constitutional right of privacy could permit him or her to refuse medical treatment under certain circumstances. First, in *Griswold v. Connecticut*,²¹ decided twelve years prior to this case in 1965, the Court "found the unwritten constitutional right of privacy to exist in the *penumbra* of specific guarantees of the Bill of Rights," and used this as the basis for protecting the right of married persons to use contraceptives free of state intervention.²² Eight years later, the Court extended the right of privacy found to exist in *Griswold* to the abortion context. It held that that a woman's right to privacy is a "fundamental" right under the Fourteenth Amendment, and limits the legislature's freedom to proscribe or regulate abortion.²³ Inferring from the Court's recent line of decisions extending an individual's constitutional right of privacy with regard to contraception and abortion, the New Jersey Supreme Court asserted this same right of privacy was similarly broad enough to encompass an individual's decision to refuse medical treatment under certain circumstances.²⁴

Having established this right, the court further concluded that Karen's constitutional right of privacy outweighed the State's claimed interests in the preservation and sanctity of human life and the defense of the right of physicians to offer medical treatment in their best professional judgment.²⁵ The court presented a sliding scale approach: the State's interest diminishes and the individual's right to privacy increases as the degree of bodily invasion increases and the prognosis worsens. At a certain point, the individual's rights

²¹ 381 U.S. 479 (1965) (emphasis added).

²² *Quinlan*, 355 A.2d at 663.

²³ *Roe v. Wade*, 410 U.S. 113 (1973).

²⁴ *Quinlan*, 355 A.2d at 663.

²⁵ *Id.* at 663-64.

overcome the State interests. Application of this sliding scale approach to Karen's case pointed unequivocally in her favor – her prognosis was extremely poor given that she would most likely never regain cognitive function, and the degree of bodily invasion was high given her need for 24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and a feeding tube. The court further concluded that given Karen's incompetence, her father, acting as her guardian, could assert her right of privacy on her behalf.²⁶

A few weeks after the decision, Karen's respirator was removed upon her father's request. She lived for another nine years on artificial nutrition and hydration before passing away due to pneumonia in July of 1985.²⁷

The *Quinlan* decision marked a significant turning point in the debate over the right to die. First, the decision established for the first time a constitutional right of privacy as the basis for refusal of life-sustaining treatment, providing legal substance and strength to an individual's personal wishes regarding the medical treatment s/he received.

Simultaneously, the decision initiated a subtle shift in ultimate medical decision-making power away from the physician towards the patient and other actors. Prior to *Quinlan*, both the general public as well as the courts held an attitude of almost deferential respect towards the decision-making of the medical community, as exemplified by the language from the initial trial court decision denying Mr. Quinlan's request to withdraw Karen's respirator:

²⁶*Id.* at 664. In addition, the court eliminated all criminal liability on the part of the physicians and hospital for removing life-sustaining treatment: "We believe, first, that the ensuing death would not be homicide but rather expiration from existing natural causes. Secondly, even if it were to be regarded as homicide, it would not be unlawful." *Id.* at 669.

²⁷HUMPHRY, *supra* note 1, at 93.

The nature, extent and duration of care by societal standards is [sic] the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician....

....

...[T]he determination whether or not Karen Ann Quinlan be removed from the respirator is to be left to the treating physician. It is a medical decision, not a judicial one. I am satisfied that it may be concurred in by the parents but not governed by them.²⁸

Members of the medical community generally agreed with Judge Muir, content to maintain the status quo by retaining all decision-making authority. During the trial, medical experts testified that removal of the respirator violated medical practices, standards, and traditions, and was ultimately a matter for the physicians, not the patient or family, to decide.²⁹ The *Quinlan* court proposed the creation of multidisciplinary ethics committees that would help physicians navigate their way through difficult medical decisions or ethical dilemmas, and relieve them of some of their burden.³⁰ These committees would be composed of physicians, social workers, attorneys, theologians, and other professionals.³¹ After the decision, a new commitment developed within medicine to promote collective rather than individual decision-making, as evidenced by the rapid growth of ethics committees in U.S. hospitals in the years that followed.³² Overall, *Quinlan* led to the redistribution of decision-making power from the medical community to the individual patient, and ushered in an era of patient autonomy and self-determination.

Finally, *Quinlan* brought issues surrounding end-of-life care to the forefront of the nation's attention. Americans became aware of the potentially dehumanizing, futile use of medical technology and the obstacles it

²⁹HUMPHRY, *supra* note 1, at 90.

³⁰In re Quinlan, 355 A.2d 647, 668 (N.J. 1976).

³¹*Ibid.*

³²See HUMPHRY, *supra* note 1, at 98 (citing studies that showed an increase in the percentage of hospitals with ethics committees from 5% in 1983 to 30% by 1985).

raised to a “dignified death.”³³ They demanded measures that would ensure that their last wishes were honored, and that their families could avoid the predicament and protracted legal battle of the Quinlans.³⁴ In response, the California Natural Death Act, the nation’s first right to die statute, was enacted in September 1976, and was followed the next year by seven other states passing similar laws.³⁵ These laws legalized “advance directives,” a term that refers to any instruction or statement regarding future medical care that takes effect in the event that the patient loses the ability to make medical decisions.³⁶ Currently, all fifty states have laws that allow some form of advance directive.³⁷

The two major types of advance directives are the living will and the health care proxy. A living will is a legal document that enables a competent adult to assert the type of medical treatment or care s/he wants or does not want should s/he become incapacitated or unable to communicate. The document guides the physician and agent in determining how aggressively to use certain medical technologies such as cardio-pulmonary resuscitation or intubation to try to keep the patient alive.³⁸

In contrast, a health care proxy is a legal document that allows the patient to appoint someone to make medical decisions on his or her behalf, including whether or not to use life-sustaining measures, in the event of decision-making incapacity. The proxy (also referred to as agent or surrogate) has the power to speak any time the patient cannot speak for him or herself, not only at the end of life. Generally, the proxy should know at what point the individual wants to discontinue treatment, or whether s/he even wants certain treatments begun in the first place. Health care proxies help effectuate the will of the patient in the event that the

³³*Id.* at 82.

³⁴*Id.* at 94.

³⁵*Ibid.*

³⁶*Ibid.*

³⁷HUMPHRY, *supra* note 1, at 95.

³⁸*Id.* at 94.

patient failed to anticipate a certain circumstance in his or her living will, and ensure that the instructions contained in the living will are implemented properly.³⁹

The wave of “advance directive” legislation, in conjunction with the significant increase in state court decisions after *Quinlan* that permitted withdrawal of life-sustaining care, further reinforced terminal patients and their families in their quest for autonomy and personal control. Almost thirty years later, the impact of the 1976 *Quinlan* decision continues to live on:

[The decision] still informs and authenticates the rights of us all to make fundamental treatment decisions at the end of life. The court’s clear articulation of the common and constitutional law justification of the concepts of personal autonomy and bodily integrity continues to define the ongoing national debate. The constitutional notions of privacy and liberty, the central role of the family and the introduction of ethics committees at the bedside reaffirmed our basic belief in the integrity of the patient, family, physician and institution as proper cooperators in choices concerning life-sustaining measures.⁴⁰

B. Cruzan v. Missouri, Department of Health⁴¹

As critical as the *Quinlan* case was for placing greater autonomy in the hands of individuals regarding end-of-life decisions and jumpstarting the right to die movement, the scope of the *Quinlan* court’s interpretation of an individual’s right to withdraw life-sustaining treatment was limited only to New Jersey. The trial and appellate courts of other states were not bound to follow the precedent set in *Quinlan* (though they could look to it as persuasive authority). Moreover, during the 1980s no federal appellate court handed down any decision pertaining to the issue, and the Supreme Court itself denied certiorari in a number of end-of-life and other related cases, thereby leaving each state free to adopt its own view of an individual’s right to

³⁹*Ibid.*

⁴¹*Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

die.⁴² However, in 1990, the Supreme Court decided its first end-of-life case, *Cruzan v. Director, Missouri Department of Health*,⁴³ changing the legal landscape of the right to die debate across the nation.

Similar to the *Quinlan* case, the facts of the *Cruzan* case were tragic, both for the person involved as well as for the family. On the evening of January 11, 1983, Nancy Cruzan lost control of her car as she was driving.⁴⁴ Her car overturned, and paramedics arrived to discover Nancy without detectable respiratory or cardiac function.⁴⁵ Although the paramedics were able to restore her breathing and heartbeat at the accident site, Nancy was without oxygen for 12 to 14 minutes – permanent brain damage generally results after 6 minutes in an anoxic state.⁴⁶ As a result, Nancy entered into a persistent vegetative state, exhibiting motor reflexes but showing no sign of cognitive function, nor expected to ever regain cognitive function again.⁴⁷ Her parents eventually asked hospital employees to terminate the artificial nutrition and hydration procedures, knowing it would cause Nancy’s death, but the hospital employees refused to honor the request without court approval.⁴⁸

The trial court approved the request, finding that Nancy had a fundamental right under the State and Federal Constitutions to refuse or direct the withdrawal of “death prolonging procedures.”⁴⁹ In addition, the court believed it had sufficient evidence to conclude that Nancy would not wish to continue with her nutrition and hydration – in a prior conversation, Nancy had expressed to her housemate friend that she would not want to continue living if unable to “live at least halfway normally.”⁵⁰ However, the Supreme

⁴²MEISEL, *supra* note 7, at § 2.03[A].

⁴³*Cruzan*, 497 U.S. 261 (1990).

⁴⁴*Id.* at 266.

⁴⁵*Ibid.*

⁴⁶*Ibid.*

⁴⁷*Ibid.*

⁴⁸*Cruzan*, 497 U.S. at 268.

⁴⁹*Ibid.* (quoting App. to Pet. for Cert. A99).

⁵⁰*Cruzan*, 497 U.S. at 268.

Court of Missouri reversed by a divided vote.⁵¹ The court declined to read a broad right of privacy in either the State or U.S. Constitution that “support[ed] the right of a person to refuse medical treatment in every circumstance.”⁵² The court further decided that given the state’s strong interest in the preservation of life, and the fact that Nancy’s conversation with her roommate did not provide “clear and convincing” evidence of her actual wishes, it could not authorize Nancy’s parents to terminate her medical treatment.⁵³

The Supreme Court granted certiorari to consider the question of “whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment under these circumstances.”⁵⁴ The Court first determined whether Nancy had any constitutional right to withdraw treatment. Beginning with the language of the Fourteenth Amendment, which provides that no State shall “deprive any person of life, liberty, or property, without due process of law,”⁵⁵ the Court proceeded to cite prior decisions in which an individual’s liberty interest was implicated by State action. Against various State interests, the Court had previously balanced an individual’s liberty interest in declining an unwanted smallpox vaccine, avoiding the unwanted administration of antipsychotic drugs, refusing the forcible injection of medication, and being transferred to a mental hospital for mandatory behavior modification.⁵⁶ The Court concluded that “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”⁵⁷ More specifically, it *assumed* for purposes of the case that “the United States Constitution would grant a competent person a

⁵¹ *Ibid.*

⁵² *Ibid.* (quoting *Cruzan v. Harmon*, 760 S.W.2d 408, 417-18 (1988) (en banc)).

⁵³ *Id.* at 268-69.

⁵⁴ *Id.* at 269.

⁵⁵ *Id.* at 278 (quoting U.S. CONST. AMEND. XIV, § 1). Although the court in *Quinlan* had previously based the right to refuse medical treatment on an individual’s constitutional right of privacy, the Court rejected this notion in a footnote. *See id.* at 279 n.7 (“Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest.”)

⁵⁶ *Id.* at 278-79.

⁵⁷ *Cruzan*, 497 U.S. at 278.

constitutionally protected right to refuse lifesaving hydration and nutrition.”⁵⁸

However, a person’s “liberty interest” is not absolute, and must be balanced by relevant state interests. Missouri had a state interest in the protection and preservation of human life. Given the “obvious and overwhelming finality” of a life and death decision, Missouri’s heightened evidentiary requirements before allowing the withdrawal of lifesaving medical treatment from an incompetent person were both legitimate and constitutional. On this basis, the Court affirmed the Missouri Supreme Court, holding that an individual’s Fourteenth Amendment guarantee of liberty did not prohibit Missouri from requiring that “evidence of the incompetent [patient]’s wishes as to the withdrawal of treatment be proved by clear and convincing evidence.”⁵⁹

Nancy continued to live on in a persistent vegetative state attached to a feeding tube after the Court’s decision. However, a few months later several of Nancy’s friends suddenly recalled prior conversations in which she had clearly expressed a desire not to continue in a condition similar to the one she was currently in. Nancy’s physician consequently dropped his opposition to the removal of the feeding tube, and with the case back in court, the trial judge ruled that “clear and convincing evidence” now existed that Nancy would not have wanted to remain alive under her circumstances. The tube was removed the following day, and on December 26, 1990, Nancy Cruzan passed away.⁶⁰

While the *Cruzan* decision may have appeared to limit an individual’s right to die by permitting Missouri

⁵⁸*Id.* at 279.

⁵⁹*Id.* at 280.

⁶⁰HUMPHRY, *supra* note 1, at 119.

to keep Nancy on life-sustaining treatment in the absence of sufficient evidence, the decision was actually a major step forward for the right to die movement. First, although the Court permitted Missouri to require a rigorous standard for end-of-life decisionmaking for incompetent patients, it did not require other states to adopt a similar standard. As a result, New York is the only other state that has followed the example of Missouri;⁶¹ the majority of other states have chosen a standard that “recognizes the patient’s right of control over bodily integrity as the subsuming essential in determining the relative balance of interests.”⁶² Second, and most importantly, the Court established that a competent individual has a Fourteenth Amendment liberty right to refuse medical treatment.⁶³ Although most state courts and a few federal trial courts had already reached this conclusion, this decision made certain what had previously only been assumed.⁶⁴ In contrast to *Quinlan*, which directly bound only the courts in the state of New Jersey, *Cruzan* “made constitutional law for the entire country.”⁶⁵

II. The Next Frontier – Physician-Assisted Suicide

During the 1990s, the primary focus of the right to die debate shifted from an individual’s right to refuse medical treatment, now well-established by the *Quinlan* and *Cruzan* cases, to the right of terminally ill

⁶¹MEISEL, *supra* note 7, at § 2.03[A][1].

⁶²*Id.* at § 2.02.

⁶³The Court assumed for purposes of the case that the Constitution would grant a competent person a right to forgo life-sustaining nutrition and hydration, an assumption that has generally been interpreted to be in effect an endorsement of such a right. *See id.* at § 2.03[A][2] (“[D]icta make clear that this right to refuse treatment includes the right to forgo life-sustaining nutrition and hydration.”) In a concurring opinion, Justice O’ Connor elaborated further on an individual’s liberty interest to refuse unwanted medical treatment: “The State’s imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual’s liberty interests as much as any state coercion.” *Cruzan*, 497 U.S. at 288.

⁶⁴MEISEL, *supra* note 7, at § 2.03[A][2].

⁶⁵George J. Annas, “*Culture of Life*” *Politics at the Bedside – The Case of Terri Schiavo*, 352 NEW ENG. J. MED. 1710-1715 (2005).

individuals to commit physician-assisted suicide (“PAS”). In PAS, a physician assists the patient to commit suicide, either by prescribing a lethal dose of medication for the patient to take himself or herself, or by personally giving the patient a lethal injection. Most PAS advocates support only the former method (thereby avoiding the claim that the physician is literally “killing” the patient), and only for patients who are terminally ill, who are not suffering from depression or other mental illness, and who are acting freely and voluntarily.

In 1980, Derek Humphry, a British journalist and leading advocate in the right to die movement, formed the National Hemlock Society, an organization whose primary objective was “to promote a climate of public opinion which is tolerant of the right of people who are terminally ill to end their own lives in a planned manner.”⁶⁶ By the early 1990s, growing public support for the right to die movement was apparent. Surveys showed that greater than half of the American public were in favor of PAS, and membership in the Hemlock Society had risen to 50,000. It was right around this time that Dr. Jack Kevorkian made himself into a household name. As controversial as he was, Kevorkian played a huge role in advancing the focus of the right to die debate from the withdrawal of care to PAS. He turned what previously had been only a theoretical possibility in the minds of many into a practical, modern-day reality.

A. Doctor Kevorkian

On the afternoon of June 4, 1990, Kevorkian, a pathologist in Detroit, Michigan, assisted his very first patient, Janet Adkins,⁶⁷ to commit suicide in the back of his Volkswagen van. He connected her intravenously to

⁶⁶HUMPHRY, *supra* note 1, at 108.

⁶⁷Mrs. Adkins suicide note, written a few hours before her death, read: “I have decided for the following reasons to take my own life. This is a decision taken in a normal state of mind and is fully considered. I have Alzheimer’s disease and I do not want to let it progress any further. I do not want to put my family or myself through the agony of this terrible disease.” Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, N.Y. TIMES, June 6, 1990, at A1.

his homemade suicide machine that delivered harmless saline solution. Upon the push of a button by Mrs. Adkins, the machine then administered thiopental sodium to induce unconsciousness, and potassium chloride to stop her heart and bring about her death.⁶⁸ Between the years of 1990 and 1999, Kevorkian proceeded to help more than 130 additional individuals commit suicide.⁶⁹ Far from making any effort to conceal his actions, Kevorkian typically documented each of the suicides he assisted with on videotape, openly admitted to his role in their deaths, and even went so far as to publicize his deeds to major newspapers and television networks.

Kevorkian was able to assist in these suicides without criminal consequences largely due to Michigan's lack of any statute that criminalized PAS.⁷⁰ Kevorkian faced trial for murder or assisted suicide three times between 1990 and 1998, and each time he was acquitted by the jury.⁷¹ His lawyer, Geoffrey Fieger, believed that the jury found the argument that Kevorkian was not actually killing people but rather relieving suffering to be most persuasive. Although the Michigan Board of Medicine suspended Kevorkian's Michigan medical license in 1991 in an 8-0 vote and rejected his subsequent appeal, Kevorkian disregarded the suspension and continued to offer patients his unique services in a private setting. Kevorkian essentially carried out PAS in Michigan beyond the reach of the law.⁷²

Kevorkian pushed the boundaries of PAS past the comfort zone of most PAS advocates – who typically advocate limiting PAS to terminally ill individuals – by helping many individuals to commit suicide who were not terminally ill. First, he helped patients who suffered from degenerative diseases such as Alzheimer's disease to commit suicide before they became mentally incompetent.⁷³ Second, he helped patients to commit

⁶⁸*Id.*

⁶⁹Dirk Johnson, *Kevorkian Sentenced to 10 to 25 Years in Prison*, N.Y. TIMES, April 14, 1999, at A1.

⁷⁰In 1992, the Michigan Legislature passed a two-year law making assisted suicide a felony. However, Kevorkian declared the statute "immoral," disobeyed it, and was never charged under it. HUMPHRY, *supra* note 1, at 135.

⁷¹A fourth trial in 1997 was declared a mistrial before it began. *Id.* at 134.

⁷²*Id.* at 137.

⁷³For example, Mrs. Adkins, Kevorkian's first patient, suffered from early stage Alzheimer's Disease when she decided to

suicide who were very sick or in a lot of pain, but not immediately dying.⁷⁴ Kevorkian received some of his harshest criticism when he helped a woman named Rebecca Badger, who claimed she had Multiple Sclerosis, to commit suicide. It was later discovered upon autopsy that she actually did not have the disease, and had managed to trick Kevorkian.⁷⁵

Kevorkian eventually pushed the limits of the law too far in 1999 when he went beyond PAS to commit active euthanasia for the first time.⁷⁶ On March 26, 1999, a jury convicted Dr. Kevorkian of second-degree murder in the death of Thomas Youk, a 52-year-old-man who suffered from amyotrophic lateral sclerosis, commonly known as Lou Gehrig's disease.⁷⁷ The evidence consisted primarily of a "60 Minutes" program that featured a videotape released by Kevorkian, showing him administering a lethal injection to Youk. In the past, Kevorkian had always had the patient administer the lethal medication himself or herself. After escaping four attempts by Michigan prosecutors to bring him to justice, Kevorkian had finally gone too far. He was sentenced to 10 to 25 years in prison, a sentence that he is still serving today.

B. Doctor Quill

As critical as Kevorkian was for drawing the public's attention to the issue of PAS, his public and complete defiance of the law "scarcely [made him] the poster boy for the right to die movement."⁷⁸ PAS advocates required a physician from the medical community with far more credibility and legitimacy to support their

seek Kevorkian's assistance. *Id.* at 133.

⁷⁴For example, in 1991, Kevorkian assisted Sherry Miller, who suffered from multiple sclerosis, and Marjorie Wantz, who experienced severe abdominal pain, to commit suicide. The cases were very controversial because neither were considered "terminally ill" (i.e., expected to die within six months). *Ibid.*

⁷⁵*Id.* at 135.

⁷⁶In PAS, the physician gives the patient the means to commit suicide, but the patient ultimately brings his or her own death about. In contrast, in active euthanasia, the physician is the agent of the patient's death, typically through lethal injection.

⁷⁷Johnson, *supra* note 69, at A1.

⁷⁸HUMPHRY, *supra* note 1, at 138.

cause. Their needs were answered in 1991 when a well-respected New York internist named Dr. Timothy Quill published an article in the *New England Journal of Medicine* (“*NEJM*”) describing his own participation in the death of one of his patients.

The precursor to Dr. Quill’s famous article was an article published in the *Journal of the American Medical Association* (“*JAMA*”) in 1988 entitled *It’s Over, Debbie*,⁷⁹ allegedly written by an anonymous physician serving as a hospital resident. In the article, the resident described administering a lethal dose of medication to a patient dying of cancer.⁸⁰ The publication of such a story in as well-respected a professional journal as *JAMA* drew a lot of attention, both from the public as well as the medical community. However, because it was never confirmed whether the story was true, and the author never made himself or herself known, many doubted its validity. The impact of the story was therefore limited.

Dr. Timothy Quill’s article published three years later in the *NEJM* had a far greater impact. In the article entitled *Death and Dignity*, Quill wrote about “Diane,” a patient of his for eight years who had been diagnosed with leukemia.⁸¹ As Diane’s symptoms worsened and her health declined, she raised the subject of assisted suicide with Quill.⁸² Although Quill initially tried other measures for her such as home hospice care, he also understood Diane’s desire for independence and control:

It was extraordinarily important to Diane to maintain control of herself and her own dignity during the time remaining to her. When this was no longer possible, she clearly wanted to die . . . I explained the philosophy of comfort care, which I strongly believe in. Although Diane understood and appreciated this, she had known of people lingering in what was called relative comfort and she wanted no part of it. When the time came, she wanted to take her life in the least painful way possible. Knowing of her desire for independence and her decision to stay in control, I thought this request made perfect sense.⁸³

⁷⁹Anonymous, *It’s Over Debbie*, 259 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 272 (1988).

⁸⁰*Id.*

⁸¹Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691-92 (1991).

⁸²*Id.* at 693.

Eventually, convinced that Diane was not depressed, Quill wrote Diane a prescription for a lethal dose of barbiturates, with mixed feelings:

I wrote the prescription with an uneasy feeling about the boundaries I was exploring – spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.⁸⁴

Three months later, after enduring considerable emotional and physical hardships, Diane was ready. She called all her friends to say a final good-bye, and met with Quill to let her know of her decision: “When we met, it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer.”⁸⁵ Two days later, upon a call from Diane’s husband, Quill arrived at their house to find Diane lying dead upon the couch.⁸⁶ Quill reported the cause of death to the medical examiner as “acute leukemia.” He knew that if he reported the cause as suicide, paramedics would have rushed over to attempt to resuscitate Diane, and therefore he sought to “protect Diane from an invasion into her . . . body.”⁸⁷ Although Quill was brought before the grand jury on July 12, 1991, approximately four months after his article had appeared, the grand jury chose not to indict him.⁸⁸

Quill’s confession in the world’s most prestigious medical journal “burst upon a grateful public desperate for an antidote to the seemingly perfunctory, speedy, back-of-the-van methods of assisted death as practiced by Kevorkian.”⁸⁹ Quill wrote about his own distress regarding Kevorkian’s methods: “[w]e should all be troubled that he helped put to death eighteen people whom he barely knew, and did so evidently without doubt or personal struggle.”⁹⁰ For many, Quill showed that PAS could be done with caution, love, justifiability,

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*

⁸⁷ *Ibid.*

⁸⁸ HUMPHRY, *supra* note 1, at 141.

⁸⁹ *Id.* at 140.

⁹⁰ *Ibid.*

and finality.

Quill's article also had a powerful effect on the medical community, causing an outpouring of similar admissions from his peers, and in a way destigmatizing the issue so that it could be discussed more openly. He received over a thousand letters, many from physicians around the country, who, like himself, had helped a patient to die, except in their case they had chosen not to reveal their actions to the public.⁹¹ In one Michigan study, 40 percent of physicians supported legalization of assisted suicide, 37 percent preferred no regulation, 5 percent were uncertain, and only seventeen percent favored prohibition.⁹²

In the following years, Quill collaborated with medical colleagues to write a series of articles in medical journals that explored PAS further. For example, in 1992, one year after his original article, Quill and two other physicians published another article in *The New England Journal of Medicine* that described a six-point series of tests a physician should conduct before assisting a suicide:

1.

The patient must have a condition that is incurable and associated with severe, unrelenting suffering, and must understand the problem;

2. Doctors must be sure patients are not asking for death only because they are not getting treatment that would relieve their suffering;

3.

The patient must clearly and repeatedly ask to die to avoid suffering without making the patient beg for assistance;

⁹¹ *Ibid.*

⁹² Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public toward Legalizing Physician-assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303 (1996).

4. A doctor must be sure a patient's judgment is not distorted or resulting from a treatable problem like depression;
5. The doctor who assists in the suicide should be the patient's physician unless he or she has moral objections;
- 6.

An independent doctor should give a second opinion in the case, with all three each signing a document showing informed consent.⁹³

Quill eventually grew to become arguably the most convincing and influential medical advocate for PAS. His continued advocacy efforts in lectures, conferences, and articles, eventually culminated in his serving as one of the lead plaintiffs in *Vacco v. Quill*⁹⁴ (discussed in Part III of this paper), one of the first PAS-related cases to be decided by the Supreme Court.

As contrasting as Kevorkian's and Quill's approaches were to the issue of PAS and their views on how it should be carried out, in the end, they were both fighting for same cause – the legalization of PAS. Their efforts and actions no doubt contributed to Oregon's eventual enactment of the unprecedented Death with Dignity Act in 1997, the first law in U.S. history to permit PAS to occur so long as certain requirements were met.

C. The Oregon Death with Dignity Act (“DWDA” or “the Act”)

Events Leading up to the DWDA's Enactment:

The DWDA was a citizen's initiative – Ballot Measure 16 – first passed by Oregon voters in November, 1994,

⁹⁴521 U.S. 793 (1997).

by the narrow margin of 51 percent to 49 percent.⁹⁵ Fifteen days before the Act was to take effect, a group of terminally ill patients, physicians, and residential care facilities filed a class action complaint alleging the Act violated their Fourteenth Amendment equal protection and due process rights, their First Amendment free exercise of religion and freedom of association rights, and their statutory rights under the Americans with Disabilities Act of 1990,⁹⁶ Section 504 of the Rehabilitation Act of 1973,⁹⁷ and the Religious Freedom Restoration Act of 1993⁹⁸.⁹⁹

The district court initially granted the plaintiffs preliminary injunctive relief, which prevented the Act from taking effect.¹⁰⁰ On August 3, 1995, the district court issued a permanent injunction against the Act's enforcement, finding that the Act violated the Equal Protection Clause.¹⁰¹ The Act failed to provide sufficient safeguards to prevent incompetent or depressed terminally ill adults from seeking physician-assisted suicide, and therefore irrationally deprived terminally ill adults of the same protections from suicide enjoyed by other members of society.¹⁰²

Oregon appealed the decision, and on February 27, 1997, the Ninth Circuit, vacated the district court judgment and remanded with instructions to dismiss the case for lack of jurisdiction.¹⁰³ The court determined that it lacked jurisdiction to hear the case under Article III of the Constitution and declined to address the merits of the case because (1) plaintiffs had failed to establish any actual injury, and therefore lacked standing, and (2) the claim of the physicians and healthcare facilities was not "ripe."¹⁰⁴ The Supreme Court denied

⁹⁵Brian Boyle, *The Oregon Death With Dignity Act: A Successful Model or a Legal Anomaly Vulnerable to Attack?*, 40 Hous. L. Rev. 1387, 1391 (2004).

⁹⁶42 U.S.C. §§ 12101 *et seq.*

⁹⁷29 U.S.C. § 791.

⁹⁸42 U.S.C. §§ 2000bb *et seq.*

⁹⁹*Lee v. State of Oregon*, 869 F.Supp. 1491, 1493, 1499-1500 (D. Or. 1994) (order granting preliminary injunction).

¹⁰⁰*Id.* at 1502-1503.

¹⁰¹*Lee v. State of Oregon*, 891 F.Supp. 1429, 1437 (D. Or. 1995).

¹⁰²*Id.* at 1438. ("[Measure 16] has lowered standards and reduced protections to a degree that there is little assurance that only competent terminally ill persons will voluntarily die. The majority has not accepted this situation for themselves, and there is no rational basis for imposing it on the terminally ill.") *Ibid.*

¹⁰³*Lee v. Oregon*, 107 F.3d 1382, 1392 (9th Cir. 1997).

¹⁰⁴*Id.* at 1390. "Standing" doctrine addresses the issue of whether a party is entitled to have the court decide the merits of

plaintiffs’ petition for certiorari.¹⁰⁵

That same year, on November 4, 1997, Oregon voters reaffirmed their support for the DWDA by defeating a ballot measure that sought to repeal the law, this time by a vote of 60 to 40 percent.¹⁰⁶ For the first time in history, a small subset of terminally ill individuals living within the United States – those who were residents of Oregon – had the option of legally seeking PAS.

How the DWDA works

The Death with Dignity Act permits terminally ill Oregon adult residents to seek and obtain a physician prescription for self-administered, lethal medications.¹⁰⁷ It specifically prohibits a physician or anyone else from ending a patient’s life by lethal injection, mercy killing or active euthanasia.¹⁰⁸ In addition, for purposes of the law, it does not consider actions taken in accordance with the Act to constitute suicide, assisted suicide, mercy killing, or homicide.¹⁰⁹ To be eligible to receive lethal medication under the Act, a patient must be (1) an adult,¹¹⁰ (2) an Oregon resident, (3) capable,¹¹¹ and (4) terminally ill¹¹².¹¹³ Both physicians and patients who meet the requirements of the Act are protected from criminal prosecution.¹¹⁴ Health care providers who do not desire to carry out a patient’s request under this Act are not obligated to do so.¹¹⁵

the dispute. *Id.* At 1387.

¹⁰⁵Lee v. Harclerod, 522 U.S. 927 (1997).

¹⁰⁶*Id.*

¹⁰⁷OR. REV. STAT. § 127.805 (2003).

¹⁰⁸§ 127.880.

¹⁰⁹*Ibid.*

¹¹⁰An individual 18 years or older. § 127.800.

¹¹¹“[P]atient has the ability to make and communicate health care decisions to health care providers...” *Ibid.*

¹¹²The patient suffers from a terminal disease that will lead to death within six months. *Ibid.*

¹¹³§ 127.805. (“An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897”). *Ibid.*

¹¹⁴§ 127.885.

¹¹⁵*Ibid.*

Beyond simply an eligible patient's expressed desire to receive lethal medication, a significant number of safeguards are incorporated in the Act in order to ensure that the patient is making a voluntary, informed decision. Some of the more notable requirements that must be met before a physician will prescribe the lethal medication to a patient include the following:

1)

The patient must make a written request to his or her physician, signed in the presence of two witnesses, one of whom is not a relative. The witnesses must attest that the patient is capable and acting of his or her own voluntary will.¹¹⁶ In addition to the written request, the patient must make two oral requests to his or her physician, separated by at least 15 days.¹¹⁷ The patient may rescind the request at any time.¹¹⁸

2)

The prescribing physician must ensure that the patient is making an informed decision by informing the patient of his or her medical diagnosis and prognosis, the potential risks and likely result of taking the medication, and other options to assisted death, including comfort care, hospice care, and pain control.¹¹⁹

3)

A second, consulting physician must examine both the patient and his or her relevant medical records, and confirm in writing that the patient is suffering from a terminal illness, and that he or she is capable and making a voluntary, informed decision.¹²⁰

4)

If either the prescribing or consulting physician believes the judgment of the patient is impaired by a psychiatric or psychological disorder, including depression, the patient must be referred for counseling. The prescribing physician may not prescribe the requested medication until the counselor determines that the patient's judgment is no longer impaired.¹²¹

5)

In order to ensure that abuses do not occur under the Act and that accurate data is obtained on the effect of the Act, both prescribing physicians and the Department of Health are under stringent documenting and reporting requirements.¹²²

Impact of DWDA in Oregon

In 2004, of the 60 patients who received prescriptions for lethal doses of medication from 40 physicians, 35 died after ingesting the medication. Another two patients who received such prescriptions in 2003 died after ingestion, making a total of 37 PAS deaths in 2004.¹²³ Of the remaining 25 patients who did not take the prescribed medication, 13 died from their underlying illnesses and 12 remained alive as of December 31,

¹²³All individuals had insurance, and all but one of the 37 individuals died at home. DEPARTMENT OF HEALTH SERVICES, SEVENTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 4 (2005) (hereinafter "OREGON REPORT").

2004.¹²⁴

Overall, the number of patients dying from lethal medication has tended to increase slightly each year since the Act's enactment – in 1998, 16 Oregonians died from PAS, followed by 27 in 1999, 27 in 2000, 21, in 2001, 38 in 2002, 42 in 2003, and 37 in 2004, for a total of 208 deaths as of December 21, 2004.¹²⁵ However, as a proportion of the total number of deaths in Oregon each year these numbers are very small, equivalent to about one of every 800 deaths. Rates of participation in PAS since the Act's enactment in 1997, as compared with other Oregonians who have died from the same underlying illnesses, generally decrease with age, and increase for those who were divorced or never married, those who were more highly educated, and those who suffered from amyotrophic lateral sclerosis (commonly known as Lou Gehrig's Disease), HIV/AIDS, or malignant neoplasms. The most frequently cited end-of-life concerns for patients who requested lethal medication were (1) a decreasing ability to enjoy life activities, (2) loss of autonomy, and (3) loss of dignity.

The forty physicians who prescribed lethal medication in 2004, specializing in family medicine (57%), oncology (22%), internal medicine (8%), and other areas (14%), had been in practice between 6 to 36 years, with a median of 22 years. The majority of the physicians wrote only one prescription.¹²⁶ Only one physician was referred to the Oregon Board of Medical Examiners for failing to submit some of the required forms in a timely manner.¹²⁷ No major complications related to taking the medication were reported, nor were emergency medical services called in any instances.¹²⁸

¹²⁴*Ibid.*

¹²⁵*Id.* at 4, 5.

¹²⁶Twenty-eight wrote one prescription, nine wrote two, one wrote three, one wrote four, and one wrote seven. *Id.* at 14.

¹²⁷*Ibid.*

¹²⁸A few of the patients vomited or fell unconscious after drinking a portion of the medication, but all eventually died within the day (though one did not die until 31 hours later). *Id.* at 15.

On the basis of the first seven years of data, PAS appears to be well-regulated in Oregon and has not resulted in the types of pressures and abuses that PAS opponents feared would occur. The small percentage of Oregonians that have sought PAS since the DWDA's enactment in 1997 has not resulted in hordes of individuals rushing to engage in PAS. In addition, no major functional setbacks or statistical "red flags" have occurred thus far, and physicians appear to be complying with the Act's lengthy list of requirements. One study has even shown that the Act has prompted Oregon physicians to address alternative end-of-life care options more effectively.¹²⁹

If the DWDA successfully survives current legal and Congressional challenges, and continues to demonstrate that PAS can occur in Oregon free of abuse and mistakes, it may prove as a model act for other states currently engaged in the PAS debate to follow in the near future. However, the future viability of the DWDA is uncertain given legal challenges that it faces currently and potentially in the future.

Legal Challenges to DWDA

First, the DWDA faces potential future Congressional challenges. The Supremacy Clause of the Constitution dictates in the event that federal and state laws conflict, federal law prevails. Thus, should Congress succeed in passing a law that prohibits PAS, that law would effectively trump the DWDA and make it invalid.¹³⁰ Of course, Oregon could respond by raising constitutional challenges to any such law based on principles of distribution of powers and federalism.¹³¹

¹²⁹OREGON REPORT, *supra* note 123 at 17 (reporting that Oregon Physicians have made efforts to improve their knowledge of pain medications, psychiatric disorders, and hospice care since the Act's initial passage in 1994).

¹³⁰A number of bills have already been introduced into Congress in an attempt to criminalize PAS – the Lethal Drug Abuse Prevention Act, which would have imposed federal criminal sanctions on doctors participating in PAS, and a proposed amendment to the CSA, which also would have prohibited doctors from participating in PAS. Both bills failed to pass in both houses of Congress. Boyle, *supra* note 95 at 1410.

¹³¹*Id.* at 1399, 1400.

Aside from actually passing a law effectively prohibiting PAS, Congress could also use its tax and spending power under the Constitution to influence the practice of PAS. For example, in 1997, President Clinton signed the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), which prohibits the use of federal money for PAS-related purposes.¹³² However, the ability of such measures to challenge the functioning of the DWDA is limited.¹³³

The primary threat to the continued existence of the DWDA is an interpretive rule issued by Attorney General John Ashcroft in 2001 (“Ashcroft Directive”), which declares that PAS violates the Controlled Substances Act of 1970 (“CSA”).¹³⁴ The Ashcroft Directive states that PAS serves no “legitimate medical purpose” under 21 C.F.R. §§ 1306.04 (a prior federal regulation implementing the CSA). Furthermore, physicians who prescribed federally controlled substances in accordance with the DWDA may have their medical licenses suspended or revoked because their actions are “inconsistent with the public interest.”¹³⁵ The Directive specifically addresses Oregon health care providers, instructing the DEA to enforce this determination “regardless of whether state law authorizes or permits such conduct by practitioners.”¹³⁶

Upon challenge of the Directive by the State of Oregon, both the District Court and the 9th Circuit have held that the Directive is both unlawful and unenforceable because it violates the plain language of the CSA, goes against the express legislative intent of Congress, and oversteps the limits of the statutory authority given to the Attorney General.¹³⁷

¹³²*Id.* at 1412.

¹³³*Id.* at 1414.

¹³⁴66 Fed. Reg. 56,607.

¹³⁵*State of Oregon v. Ashcroft*, 368 F.3d 1118, 1123 (2004). In 1984, Congress amended the CSA to give broader authority to the Attorney General to revoke a physician’s prescription privileges in the event that the physician committed acts inconsistent with the public interest. *Id.* at 1122.

¹³⁶*Id.* at 1123 (quoting 66 Fed. Reg. at 56,608).

¹³⁷*Id.* at 1120.

In sum, the CSA was enacted to combat drug abuse. To the extent that it authorizes the federal government to make decisions regarding the practice of medicine, those decisions are delegated to the Secretary of Health and Human services, not to the Attorney General. The Attorney General's unilateral attempt to regulate general medical practices historically entrusted to state lawmakers interferes with the democratic debate about physician assisted suicide and far exceeds the scope of his authority under federal law. We therefore hold that the Ashcroft Directive is invalid and may not be enforced.¹³⁸

The Supreme Court granted Ashcroft's petition for certiorari, and will hear the case next term in November, 2005. The Court's determination of the case has huge implications for the right to die movement. If the Court decides in favor of the Attorney General and against Oregon, the future of PAS in this country looks unpromising – states will effectively be barred from permitting the practice of PAS within their borders. On the other hand, if the Court decides in favor of Oregon, states would be free to follow Oregon's lead – it is conceivable that a wave of legislation permitting the practice of PAS could sweep across the country, similar to the “advance directive” legislation that followed in the wake of the *Quinlan* decision in 1976.

III. Physician-Assisted Suicide in the Federal Courts

As efforts took place in Oregon during the mid 90s to advance PAS on the state-wide level through the voter referendums, concurrent efforts were being made to advance PAS on the federal level through the judiciary. In 1994, two cases were brought simultaneously in Washington and New York federal district courts to challenge state statutes that effectively prohibited or criminalized PAS. Right to die advocates ambitiously sought to expand the Supreme Court's recognition in *Cruzan* of an individual's “constitutionally protected liberty interest in refusing unwanted medical treatment”¹³⁹ to include a constitutional right to commit PAS.

¹³⁹*Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990).

A. Ninth Circuit

In the first case, *Compassion in Dying v. Washington*,¹⁴⁰ the plaintiffs consisted of three mentally competent, terminally ill persons, five well-respected physicians who regularly treated terminally ill patients, and Compassion in Dying, a nonprofit organization which provides counseling and assistance to terminally ill patients considering suicide. They raised a facial challenge to a Washington statute which made it a felony to “knowingly cause [] or aid [] another person to attempt Suicide,”¹⁴¹ asserting that the statute violated a mentally competent, terminally ill adult’s Fourteenth Amendment right to commit PAS without undue governmental interference.

The series of reversals that accompanied this case, from the federal district court all the way up to the Supreme Court, is indicative of how divided the judiciary stood on the constitutionality of PAS. Initially, the district court granted summary judgment for the plaintiffs, looking primarily to *Casey* and *Cruzan* to reach the unprecedented conclusion that “a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted suicide.”¹⁴² It further reasoned that because the Washington statute placed an undue burden on the exercise of that constitutionally-protected liberty interest,¹⁴³ the statute was invalid insofar as it applied to PAS.¹⁴⁴

On appeal, a three-judge panel of the Ninth Circuit voted 2-1 to reverse the district court decision, finding

¹⁴⁰850 F.Supp. 1454 (W.D. Wash. 1994), aff’d in part, 79 F.3d 790 (9th Cir. 1996) (en banc), rev’d sub nom., *Washington v. Glucksberg*, 521 U.S. 702 (1997).

¹⁴¹WASH. REV. CODE ANN. § 9A.36.060 (1991). A conviction could result in five years in prison and a \$10,000 fine. §§ 9A.36.060(2), 9.20.020(1)(c).

¹⁴²*Compassion in Dying*, 850 F.Supp. at 1462.

¹⁴³*Id.* at 1467.

¹⁴⁴The district court also reached this conclusion based on its holding that the statute violated the Equal Protection Clause because it impermissibly treated similarly situated groups of terminally ill patients differently. This line of reasoning is not explored in depth here because it did not play a major factor in the case’s subsequent history.

no basis for concluding that the statute violates the Constitution.¹⁴⁵ Writing the opinion, Judge Noonan made it clear that there is no constitutional right to PAS:

In the two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction. Unless the federal judiciary is to be a floating constitutional convention, a federal court should not invent a constitutional right unknown to the past and antithetical to the defense of human life that has been a chief responsibility of our constitutional government.¹⁴⁶

Noonan criticized the district court for lifting language from *Casey* out of its abortion context and applying it to the completely different context of PAS.¹⁴⁷ He further went on to argue that Washington's various state interests "individually and convergently outweigh any alleged liberty of suicide."¹⁴⁸ Based on this reasoning, Noonan reversed the district court.

However, the Ninth Circuit decided to rehear the case en banc. The en banc court reversed the appellate court's earlier decision, and affirmed the district court's original decision by an 8-3 vote. Writing for the circuit court, Judge Reinhardt concluded that there is in fact a constitutionally-protected liberty interest in determining the time and manner of one's own death. He further found that the provision of the Washington statute banning assisted suicide, as it applied to competent, terminally ill adults who wished to obtain lethal medication from their physicians, violated the Due Process Clause, and was therefore invalid.¹⁴⁹ The case went up on appeal to the Supreme Court.

B. Second Circuit

¹⁴⁵ *Compassion in Dying v. State of Washington*, 49 F.3d 586 (9th Cir. 1995).

¹⁴⁷ *Id.* at 590.

¹⁴⁸ *Id.* at 591.

¹⁴⁹ *Id.* at 793-94.

Meanwhile, three thousand miles away on the east coast, in *Quill v. Koppell*,¹⁵⁰ a group of terminally ill patients and their physicians challenged two New York statutes, which, similar to the one challenged in the Ninth Circuit, made it a felony to aid a person in committing suicide or attempting to commit suicide. The plaintiffs raised Due Process and Equal Protection claims that were virtually identical to those asserted in the Washington litigation.¹⁵¹ They argued that the provisions of the statutes, as applied to a physician who assists a mentally competent, terminally ill adult to avoid continued suffering by prescribing lethal drugs, violated the Constitution.

Unlike the district court in *Compassion in Dying v. Washington*, the New York District Court entered summary judgment dismissing plaintiffs' action. Applying a "history and tradition" test, the court concluded that the historical rejection of assisted suicide as either legally or morally acceptable barred the Due Process claim. The court also rejected the Equal Protection claim, finding that the State was rational in recognizing a difference between "refusing treatment in the case of a terminally ill person and taking a dose of medication which leads to death."¹⁵²

However, upon appeal, the Court of Appeals for the Second Circuit affirmed in part and reversed in part. Similar to the lower court, the Court of Appeals found that there is no fundamental right to assisted suicide. The court expressed great reluctance to identify new fundamental rights in the absence of clear direction from the Supreme Court, or to "undertake an expansive approach in this uncharted area."¹⁵³ Unlike the lower court, however, the Court of Appeals held that the New York statute violated the plaintiffs' Equal

¹⁵⁰870 F.Supp. 78 (1994).

¹⁵¹One noteworthy difference is that the New York challenge was as-applied in nature, versus the Washington challenge which was both as-applied and facial. *Compare* Quill v. Vacco, 80 F.3d 716, 719 (2d Cir. 1996) (recounting that plaintiffs challenged the statute "as applied to physicians...") *with* Compassion in Dying v. State of Washington, 79 F.3d 790, 797 (9th Cir. 1996) (stating that plaintiffs challenged the statute's "or aids" provision "both on its face and as applied to terminally ill, mentally competent adults who wish to hasten their deaths with the help of medication prescribed by their doctors.").

¹⁵²*Quill*, 870 F.Supp. at 84-85.

¹⁵³*Quill*, 80 F.3d at 724-25.

Protection rights. The court found that the statutes failed to treat similarly situated persons alike: “[T]hose in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.” Applying rational basis scrutiny, the court failed to find that the different treatment was rationally related to any legitimate state interest. The court reversed the district court and entered judgment in favor of the plaintiffs.

In both the Washington and New York cases, the federal courts of appeals upheld the claims of the plaintiffs and held the statutes that criminalized aiding suicide unconstitutional. The two appellate decisions in effect made PAS legally available to the qualifying people of almost one-fourth the population of the United States. “I have always thought that society would move toward some sort of legalization of assisted suicide, but I thought it would take the better part of a decade, not the better part of a year,” said Arthur Caplan, director of the Center for Bioethics and Trustee Professor of Bioethics at the University of Pennsylvania. “You’re talking about a sea change – overnight – in public policy on this issue.”¹⁵⁴

The victory for the right to die movement and PAS advocates, however, was short-lived. The U.S. Supreme Court granted certiorari in both cases, heard and decided the cases together, and ultimately reversed the holdings of both courts of appeals.

C. The Supreme Court

¹⁵⁴Frank Bruni, *Court Overturns Ban in New York on Aided Suicides*, N.Y. TIMES, April 3, 1996.

Washington v. Glucksberg.¹⁵⁵

Chief Justice Rehnquist, author of *Cruzan* and lead dissenter in *Casey*, wrote the majority opinions, joined by Justices Kennedy, Thomas, Scalia, and O'Connor.

In reversing the ruling of the Ninth Circuit Court of Appeals, Rehnquist held that (1) the right to assistance in committing suicide was not a fundamental liberty interest protected by the Due Process Clause of the Constitution, and (2) Washington's ban on assisted suicide was rationally related to legitimate government interests.

Rehnquist first determined that an individual does not have a constitutional right to assistance in committing suicide. The Due Process Clause affords special protection to those fundamental rights and liberties that are "deeply rooted in this Nation's history and tradition,"¹⁵⁶ and "implicit in the concept of ordered liberty" such that "neither liberty nor justice would exist if they were sacrificed."¹⁵⁷ In addition to the specific freedoms under the Bill of Rights, the "liberty" specially protected by the Clause includes the rights to marry, to have children, to direct the education and upbringing of one's children, to marital privacy, to the use of contraception, to bodily integrity, and to abortion.¹⁵⁸ In *Cruzan*, the Court both assumed and strongly suggested that the Clause additionally protects the right to refuse unwanted lifesaving medical treatment.¹⁵⁹

Rehnquist found that far from having any place in our Nation's traditions, the right to commit suicide with

¹⁵⁵Washington v. Glucksberg, 521 U.S. 702 (1997).

¹⁵⁶*Id.* at 721 (quoting Moore v. East Cleveland, 431 U.S. 494, 502 (1977) (plurality opinion)).

¹⁵⁷*Ibid.* (quoting Palko v. Connecticut, 302 U.S. 319, 325, 326 (1937)).

¹⁵⁸*Id.* at 720 (internal citations omitted).

¹⁵⁹*Ibid.* (citing Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 278-279 (1990)).

another's assistance¹⁶⁰ has been met with a "consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for terminally ill, mentally competent adults."¹⁶¹ To extend constitutional protection to such a right would "reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State."¹⁶²

Furthermore, Rehnquist found unconvincing the Respondents' argument based on *Casey*. Respondents had argued that the Court's rationale in *Casey* for protecting a woman's personal and intimate decision to have an abortion also applied to the context of end-of-life decisions:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.¹⁶³

They further emphasized, relying upon both *Casey* and *Cruzan*, that "few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain."¹⁶⁴

Rehnquist, however, distinguished both the constitutionally-protected rights given protection in *Casey* and *Cruzan* from the right to assisted suicide. In *Cruzan*, the assumed right to refuse unwanted medical treatment is one that has historically been protected by the law, and thus distinct from the right to assisted suicide:

¹⁶⁰*Id.* at 724. Note that Rehnquist framed the liberty interest broadly as "the right to commit suicide with another's assistance," versus the narrow framing of the plaintiffs: the "liberty of competent, terminally ill adults to make end-of-life decisions free of undue government interference." *Ibid.* (quoting Brief for Respondents 10).

¹⁶¹*Washington v. Glucksberg*, 521 U.S. 702, 723 (1997).

¹⁶²*Ibid.*

¹⁶⁴*Id.* at 13 (quoting *Compassion in Dying v. State of Washington*, 79 F.3d 790, 813 (9th Cir. 1996)).

Given the common-law rule that forced medication was a battery, and the long legal tradition [of informed consent] protecting the decision to refuse unwanted medical treatment, our assumption [that a competent person had a constitutionally protected right to refuse lifesaving hydration and nutrition] was entirely consistent with this Nation's history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection.¹⁶⁵

As for *Casey*, Rehnquist pointed out that simply because “many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected.”¹⁶⁶ Earlier in the opinion, Rehnquist emphasized that whenever the Court extends constitutional protection to an asserted right or liberty interest, the general effect is to “place the matter outside the arena of public debate and legislative action.”¹⁶⁷ Thus, the Court must proceed carefully before expanding those rights covered by the Due Process Clause, “lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the Members of this Court.”¹⁶⁸

Once Rehnquist determined that the right to assisted suicide is not a fundamental liberty interest, and therefore did not warrant strict scrutiny, he straightforwardly showed that Washington's assisted-suicide ban was rationally related to legitimate government interests. Rehnquist identified the same six state interests discussed in the Ninth Circuit opinion: (1) preserving life, (2) preventing suicide, (3) avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence, (4) protecting family members and loved ones, (5) safeguarding the integrity of the medical profession, and (6) preventing future movement toward euthanasia and other abuses.¹⁶⁹ He found all these interests to be “unquestionably important” and at least

¹⁶⁶ *Id.* at 727-728 (citing *San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. 1, 33-35 (1973)).

¹⁶⁷ *Id.* at 720.

¹⁶⁸ *Id.* (citing *Moore v. East Cleveland*, 431 U.S. 494, 502 (1977) (plurality opinion)).

¹⁶⁹ *Id.* at 727 n.20 (citing *Compassion in Dying*, 79 F.3d at 816-832).

“reasonably related” to the statute, and finding it unnecessary to do a balancing test, ultimately reversed the en banc Court of Appeals and rejected the plaintiffs’ challenges.¹⁷⁰ Rehnquist concluded with the implication that the forum to determine the appropriateness of PAS was outside the courts amongst the people: “Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”¹⁷¹

Vacco v. Quill:¹⁷²

Rehnquist likewise reversed the Second Circuit, holding that New York’s prohibition on assisted suicide did not violate the Equal Protection Clause. The Equal Protection Clause, which demands that no State shall “deny to any person within its jurisdiction the equal protection of the laws,” embodies the general principle that States must treat like cases similarly but have discretion to treat unlike cases accordingly.¹⁷³ In this case, however, Rehnquist found that neither the assisted-suicide ban nor the New York law permitting patients to refuse medical treatment drew any distinctions between persons, or treated anyone differently from anyone else: “*Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist suicide.”¹⁷⁴

Rehnquist, unlike the Court of Appeals, drew what he believed to be an important, logical, and rational distinction between assisting suicide and withdrawing life-sustaining treatment, “a distinction widely recog-

¹⁷⁰*Id.* at 735 (“We need not weigh exactly the relative strengths of these various interests.”)

¹⁷¹*Ibid.*

¹⁷²*Vacco v. Quill*, 521 U.S. 793 (1997)

¹⁷³*Id.* at 799 (1997) (citing *Plyler v. Doe*, 457 U.S. 202, 216 (1982)).

¹⁷⁴*Id.* at 800.

nized and endorsed in the medical profession,”¹⁷⁵ and one that is based in the fundamental legal principles of causation and intent. First, regarding causation, Rehnquist argued that the cause of death of a patient who refuses life-sustaining treatment typically results from the underlying fatal disease or pathology. In contrast, the cause of death of a patient who ingests lethal medication prescribed by a physician is the medication itself, and not the disease or affliction that the patient suffers from.

Second, Rehnquist asserted that the physician who withdraws life-sustaining treatment in accord with the patient’s wishes intends to respect the patient’s wishes and to cease subjecting the patient to futile or degrading treatment. Similarly, the physician who prescribes painkilling drugs for palliative care, even though the drugs may have the double effect of hastening the patient’s death, intends to alleviate the patient’s pain. However, the physician who assists a patient to commit suicide “must, necessarily and indubitably, intend primarily that the patient be made dead.”¹⁷⁶

Looking at “intent” from the patient’s perspective, a patient who commits suicide

intends to end his or her own life, while a patient who refuses or discontinues treatment may have other intentions – for example, to live free of unwanted medical technology and other interventions.¹⁷⁷ The law does not distinguish between two events solely based on the end result – it also distinguishes between “actions taken ‘because of’ a given end from actions taken ‘in spite of’ their unintended but foreseen consequences.”¹⁷⁸

¹⁷⁵*Id.* But see *id.* n.6 (recognizing that differences of opinion do exist within the medical profession on this question; i.e., some physicians fail to see any distinction between assisting suicide and withdrawing life-sustaining treatment).

¹⁷⁶*Id.* at 802 (quoting Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass)).

¹⁷⁷*Ibid.*

¹⁷⁸*Id.* at 802-803 (quoting *Personnel Administrator of Mass. v. Feeney*, 442 U.S. 256, 279 (1979)).

Drawing upon the above reasoning, the prior opinions of state and federal courts, and the general agreement of state legislatures, Rehnquist concluded that New York drew a logical and longstanding distinction between refusing unwanted medical treatment and seeking physician-assisted suicide, and that its decision to allow everyone to pursue the former while prohibiting anyone from pursuing the latter was consistent with the Constitution. The legislative classification established by New York bore a rational relation to legitimate state interests, discussed in great detail in the *Glucksberg* opinion, and therefore was constitutionally permissible.¹⁷⁹

Rehnquist's majority opinion appeared to be a decisive defeat for right to die advocates. The Court rejected both the Due Process and Equal Protection claims unanimously. However, in two footnotes, one in each opinion, Rehnquist apparently left an "open door" to future constitutional challenges.¹⁸⁰ Justice Stevens had indicated in a concurring opinion that he did not "foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge."¹⁸¹ Rehnquist responded in a footnote that the holding "does not absolutely foreclose such a claim," but qualified his statement by stating: "[h]owever, given our holding that the Due Process Clause of the Fourteenth Amendment does not provide heightened protection to the asserted liberty interest in ending one's life with a physician's assistance, such a claim would have to be quite different from the ones advanced by respondents here."¹⁸² Rehnquist made a similar statement in footnote 13 of the *Quill* majority opinion, explaining that a future plaintiff challenging a state ban would need to present "different and considerably

¹⁷⁹*Id.* at 808-809.

¹⁸⁰Adam J. Cohen, Note, *The Open Door: Will the Right to Die Survive Washington v. Glucksberg and Vacco v. Quill?*, 16 IN THE PUBLIC INTEREST 79, 98 (1997).

¹⁸¹*Washington v. Glucksberg*, 521 U.S. 702, 750 (1997).

¹⁸²*Id.* at 734 n.24.

stronger arguments” than did the plaintiffs in the case at hand.¹⁸³ Thus, the Court appears to be “keeping the door open, but not very wide, to the possibility that it might sometime in the future invalidate a statute banning assisted suicide.”¹⁸⁴

However, as the recent Terri Schiavo controversy has made abundantly clear, the current legislative and executive branches of the federal government are committed to doing all within their power to “close the door.”

IV. The Schiavo Controversy

The recent highly-publicized controversy surrounding Terri Schiavo divided the nation along multiple lines: Terri’s husband versus her parents, liberals versus conservatives, secular versus religious factions, the right of self-determination versus the “right to life,” Congress versus the judiciary, and federal power versus state rights. It also raised many issues that have no easy answers. In the absence of explicit instructions, how does one determine a patient’s intentions? If members of one’s immediate family disagree about the type of care one should receive, who should have the final say? How does one know for certain whether a patient is in a persistent vegetative state or is “minimally conscious”? Do we have a right to take into account “quality of life” when determining whether to keep a patient on life-sustaining treatment? Important as these question

¹⁸³*Vacco v. Quill*, 521 U.S. 793, 809 n.13 (1997).

¹⁸⁴MEISEL, *supra* note 1, at § 12.05[A][1][a][iii].

are, right to die advocates were primarily concerned with one issue in particular that the Schiavo controversy brought to light – the willingness of the Executive and Legislative branches at both the state and federal levels to usurp the judiciary role and violate basic principles of federalism in an effort to promote a “culture of life.”

A. Background

On February 25, 1990, 26-year-old Terri Schiavo suffered cardiac arrest, most likely due to a severe potassium deficiency from her eating disorder.¹⁸⁵ The loss of oxygen to her brain caused her to fall into a persistent vegetative state. During the first few years after her tragedy, Terri’s husband, Michael Schiavo, and her parents (the Schindlers), got along well together, doing all they could to ensure Terri’s comfort. Michael even enrolled in nursing school to better care for Terri.¹⁸⁶

The relationship between Michael and the Schindlers came apart in 1993 over money. Michael had brought a malpractice lawsuit against the obstetrician who oversaw Terri’s fertility therapy, asserting that the physician should have detected Terri’s potassium imbalance. A one million dollar settlement between the parties resulted in a trust fund of \$700,000 for Terri’s medical care, and \$300,000 for Michael.¹⁸⁷ Michael and the Schindlers got into a heated argument over how to spend the award money, and stopped speaking to each other afterwards.¹⁸⁸

The relationship between them only grew worse over the next few years. The Schindlers made multiple

¹⁸⁵Arian Campo-Flores, *The Legacy of Terri Schiavo*, NEWSWEEK 22, 24 (April 4, 2005).

¹⁸⁶*Ibid.*

¹⁸⁷*Id.* at 25.

¹⁸⁸*Id.* at 25-26.

unsuccessful attempts to remove Michael as Terri's guardian, accusing him of abuse, neglect, and adultery.¹⁸⁹ In 1998, having given up hope that Terri would ever regain cognitive function, Michael petitioned a Florida state court to remove Terri's feeding tube over the strong objection of the Schindlers.¹⁹⁰ Although Terri had not left any advanced directive, the judge determined through trial testimony that clear and convincing evidence existed that Terri Schiavo was in a permanent or persistent vegetative state, and that she would choose to discontinue life-sustaining treatment if she could decide for herself.¹⁹¹ The appeals court affirmed the decision, and the Florida Supreme Court declined to review it.¹⁹²

The tube was disconnected in 2001, only to be restored days after when the Schindlers brought an additional appeal claiming they had newly discovered evidence.¹⁹³ The trial judge, based on the findings of five additional physicians who examined Terri, affirmed the original decision of the first trial court judge.¹⁹⁴ The appellate court affirmed the trial judge's decision after reviewing the extensive testimony in the case:

[D]espite the irrefutable evidence that [Schiavo's] cerebral cortex has sustained the most severe of irreparable injuries, we understand why a parent who had raised and nurtured a child from conception would hold out hope that some level of cognitive function remained. If Mrs. Schiavo were our own daughter, we could not but hold to such a faith. But in the end, this case is not about the aspirations that loving parents have for their children. It is about Theresa Schiavo's right to make her own decision, independent of her parents and independent of her husband.¹⁹⁵

For the second time, the Florida Supreme Court refused to hear an appeal.¹⁹⁶ The controversy would have finally reached its conclusion after five years of bitter litigation, were it not for an unprecedented action by Florida's legislative and executive branches.

¹⁸⁹ *Ibid.* Michael had moved in together with his new girlfriend, and they eventually had two children together. *Ibid.*

¹⁹⁰ *Id.* at 26.

¹⁹¹ Annas, *supra* note 65 at 1711.

¹⁹² *Ibid.*

¹⁹³ *Ibid.*

¹⁹⁴ *Ibid.*

¹⁹⁶ Annas, *supra* note 65 at 1712.

B. The Florida Legislature Intervenes

The Schindlers, with the extensive financial and political support of conservative religious organizations, went to the state legislature for help.¹⁹⁷ On October 21, 2003, the Florida Legislature passed an unprecedented new law, dubbed “Terri’s Law,” that granted Florida Governor Jeb Bush the authority to order that Terri’s tube be reinserted for the second time, which he promptly did. Although the law does not mention Terri Schiavo’s name anywhere, it is clear from the language of the statute that it was intended for Terri and Terri alone. It states in full:

Section 1. (1) The Governor shall have the authority to issue a one-time stay to prevent the withholding of nutrition and hydration from a patient if, as of October 15, 2003:

- (a) That patient has no written advanced directive;
- (b) The court has found that patient to be in a persistent vegetative state;
- (c) That patient has had nutrition and hydration withheld; and
- (d) A member of that patient’s family has challenged the withholding of nutrition and hydration.

(2) The Governor’s authority to issue the stay expires 15 days after the effective date of this act, and the expiration of the authority does not impact the validity or the effect of any stay issued pursuant to this act. The governor may lift the say authorized under this act at any time. A person may not be held civilly liable and is not subject to regulatory or disciplinary sanctions for taking any action to comply with a stay issued by the Governor pursuant to this act.

(3) Upon issuance of a stay, the chief judge of the circuit court shall appoint a guardian ad litem for the patient to make recommendations to the Governor and the court.

Section 2. This act shall take effect upon becoming a law.¹⁹⁸

¹⁹⁷They showed members of the legislature the famous videotape seen on television networks throughout the nation of Terri appearing to smile to her mother. Michael C. Dorf, *How the Schiavo Federal Court Case Might Have Been Won* (March 26, 2005), at <http://writ.findlaw.com/dorf/20040326.html>.

That same day Michael Schiavo challenged the law on constitutional grounds, and the circuit court found in favor of Michael Schiavo. Upon appeal, on September 23, 2004, the Florida Supreme Court affirmed the lower court, concluding that Terri's law was unconstitutional both on its face and as applied to Terri because it violated the "fundamental constitutional tenet of separation of powers."¹⁹⁹ The court stated that separation of powers is the "cornerstone of American democracy," a time-honored principle that recognizes three distinct branches of government – the executive, the legislative, and the judicial – each possessing its own unique powers and responsibilities.²⁰⁰ In line with this principle, both the Florida Constitution and case law expressly prohibit one branch from intruding into the domain or exercising the powers of the other two branches.²⁰¹ Given this context, it was "without question an invasion of the authority of the judicial branch for the Legislature to pass a law that allow[ed] the executive branch to interfere with the final judicial determination in a case . . . and for that reason the Act is unconstitutional as applied to Theresa Schiavo."²⁰²

In addition to finding the Act unconstitutional as applied in the case of Terri Schiavo because it encroached upon judicial power, the court further found the Act unconstitutional on its face because it delegated legislative power to the Governor.²⁰³ Under Article II, section 3 of the Florida Constitution, the Legislature "may not delegate the power to enact a law or the right to exercise unrestricted discretion in applying the law," a prohibition also known as the nondelegation doctrine.²⁰⁴ The purpose of the doctrine is to ensure that important policy decisions are made by the legislature, who is elected specifically to perform those tasks. The court found that in enacting Terri's Law, the legislature failed to provide standards by which the Governor should determine whether a stay should be issued, how long it should remain in effect, and what

¹⁹⁹Bush v. Schiavo, 885 So.2d 321, 329 (Fla. 2004).

²⁰⁰*Ibid.*

²⁰¹*Ibid.*

²⁰²*Id.* at 332.

²⁰³*Ibid.*

²⁰⁴*Ibid.*

criteria needed to be met for lifting the stay. As such, the Act essentially gives the Governor “absolute, unfettered discretion” to decide whether to issue and then when to lift a stay, and thus clearly violates the nondelegation doctrine.²⁰⁵

The court concluded by re-emphasizing the importance of separation of powers to the nation’s constitutional system of government, and the ills that would follow if this bedrock democratic principle is compromised:

[T]his case is about maintaining the integrity of a constitutional system with three independent and coequal branches, none of which can either encroach on the powers of another branch or improperly delegate its own responsibilities. . . . If, without the assent of the Governor, the courts can do what was attempted here, the executive branch will be subordinated to the final directive of the other branches. Also, the rights of individuals No court judgment could ever be so secure if no constitutional right truly secure, because the precedent of this case is to the contrary.²⁰⁶

The Supreme Court refused to hear Governor Bush’s appeal in January 2005. On March 18, 2005, after many additional unsuccessful attempts by the Schindlers to delay the removal of Terri’s tube, Terri’s tube was removed for the third time in compliance with a Florida court order.

C. Congress Intervenes

In a virtual repeat of the Florida Legislature’s unprecedented intrusion into the Judiciary branch on behalf of a single individual, the legislative and executive branches engaged in the same maneuver, except this time on a federal level. On March 19th, the U.S. Senate delayed its Easter recess and worked through the weekend to adopt a bill on March 20, Palm Sunday, entitled “For the relief of the parents of Theresa Marie Schiavo.”²⁰⁷ The U.S. House of Representatives returned from Easter recess for a special session to

²⁰⁵*Id.* at 334.

²⁰⁷S. 686, 109th Cong. (2005).

debate S.686 the following day, and voted to pass the bill 203-58 shortly after midnight on March 21. The congressional debates, which were covered live on television by C-SPAN, contained frequent references to erring on the “side of life,” taking action to “prevent death by starvation,” ensuring the “right to life”, and “protect[ing] the rights of disabled people.”²⁰⁸ President Bush flew back to Washington from his ranch in Crawford, Texas, for the express purpose of signing the Schiavo bill into law (“Terri’s Law II”),²⁰⁹ which he did at 1:11 a.m.²¹⁰

Terri’s Law II granted jurisdiction to the Florida federal district court to hear the Schindlers’ case (despite the fact that the court had previously held that it lacked jurisdiction), and ordered the court to look at the claims “de novo” without regard for prior state court decisions.²¹¹ It further authorized the court to “issue such declaratory and injunctive relief as may be necessary to protect the rights of Theresa Marie Schiavo under the Constitution and laws of the United States relating to the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain her life.”²¹²

The law has been criticized for three main reasons. First, Terri’s Law II undermines the purpose and nature of legislation. Legislation is supposed to be broad in scope and prospective, however Terri’s Law II affected only a single individual in a single lawsuit, and was retrospective.²¹³ Second, Terri’s Law II violates basic notions of constitutional federalism, which requires that the federal government respect “states’ rights.” Congress ordered the federal courts to disregard over a decade of state court litigation and final judgments, and authorized the federal court to give de novo reconsideration to questions of law in addition to questions

²⁰⁸Annas, *supra* note 65 at 1713.

²⁰⁹Relief of the Parents of Theresa Marie Schiavo, Pub. L. No. 109-3, 119 Stat. 15 (2005).

²¹⁰Campo-Flores, *supra* note 185 at 28.

²¹¹Pub. L. No. 109-3. §§ 1-2.

²¹²*Ibid.*

²¹³Edward Lazarus, *Why Congress’s Intervention Predictably Didn’t Help the Schindlers: Putting Federal Judges in an Unfair Pressure Cooker In the Terri Schiavo Case* (March 31, 2005) at <http://writ.findlaw.com/lazarus/20050331.html>.

of fact, thereby undermining the judicial process and decisionmaking of the Florida state courts.²¹⁴ Finally, Terri's Law II infringes upon the constitutional right of a patient to refuse life-saving medical treatment. *Cruzan* stood for the principle that when clear and convincing evidence exists that a patient wishes to have a feeding tube disconnected, the government cannot intervene to the contrary. Yet Terri's Law did just this. It authorized federal courts to rehear the case, thereby prolonging Terri's attachment to the feeding tube during the proceedings, even after the Florida courts had determined Terri's constitutional right to be disconnected by clear and convincing evidence.²¹⁵

Congress's unprecedented intervention on behalf of Terri Schiavo came to no avail. U.S. District Judge James D. Whittemore denied the request of the Schindlers for a temporary restraining order that would require reinsertion of the feeding tube, concluding that the parents had failed to demonstrate "a substantial likelihood of success on the merits" of the case (the requisite standard for a temporary restraining order).²¹⁶ Whittemore's decision was upheld on appeal, and the Supreme Court denied the parents' petition for certiorari.²¹⁷ On March 31, 2005, at 9:05 a.m., thirteen days after her tube had been removed for the third time, Terri Schiavo passed away, bringing to a close a seven-year legal battle and the longest right to die case in history.

²¹⁴ *Ibid.*

²¹⁵ *Ibid.*

²¹⁶ *Schiavo ex rel. Schindler v. Schiavo*, 357 F.Supp.2d 1378 (M.D.Fla. 2005).

²¹⁷ *Schiavo ex rel. Schindler v. Schiavo*, 125 S.Ct. 1692 (2005).

Conclusion

This paper has traced the evolution of the right to die movement from its beginnings in the 1970s until today. Initially, the movement focused on securing the right of an individual to withhold or withdraw medical treatment, even if the treatment was necessary for that individual to stay alive. The movement was officially set into motion in 1976 when the New Jersey Supreme Court upheld the constitutional right of an individual to refuse life-sustaining medical treatment. Following the decision, states across the nation enacted “advance directive” legislation that permitted individuals to exert a high degree of control over the medical decisions that would be made about their care in the event that they became incompetent or unable to make such decisions. Although the Court’s 1990 *Cruzan* decision may have appeared to be a setback for the movement because the parents who sought to withdraw their daughter’s feeding tube ultimately lost, in fact it served as a major boost. The Court recognized for the first time an individual’s constitutionally protected liberty right to refuse medical treatment, a decision that unlike *Quinlan*, which bound only the courts of New Jersey, applied to state and federal courts everywhere.

The years following *Cruzan* in the 1990s witnessed a shift in the focus of the right to die movement from withdrawal of care to PAS. The very same year that *Cruzan* was decided in 1990, Dr. Kevorkian publicized the first PAS that he had orchestrated in the back of his van. One year later, Dr. Quill responded to the controversial, media-focused approach of Kevorkian by writing thoughtfully and reflectively of his own experience with PAS in the *NEJM*. Despite their contrasting methods, both physicians raised awareness of and dialogue around the issue, both within the medical community and the public at large. Subsequently, in 1994 and again in 1997, Oregonians made it clear in two separate referendums that they supported the

legalization of PAS. Oregon's ultimate passage of the Death with Dignity Act represented the high-water mark of the right to die movement – for the first time in history a state had legalized PAS (subject to strict requirements).

However, recently the right to die movement has suffered a series of setbacks that threaten to roll back many of the changes it worked so hard to obtain. First, in 1997, the same year that Oregon enacted its DWDA, the Supreme Court overturned both the Ninth and Second Circuit decisions that had found state statutes criminalizing assisted suicide to be unconstitutional. The Court, though willing to extend constitutional protection to an individual's right to refuse medical treatment, was not prepared to extend such protection to an individual's right to commit PAS. Second, in 2001, Attorney General John Ashcroft, intent upon undermining Oregon's DWDA and preventing other states from adopting similar legislation, issued an interpretive rule (the "Ashcroft Directive") that declares that PAS violates the Controlled Substances Act of 1970. If the Supreme Court upholds the Ashcroft Directive next term, Oregon physicians will effectively be barred from participating in PAS, and other states will be precluded from enacting PAS legislation similar to Oregon. Finally, the recent Schiavo controversy has highlighted a willingness on the part of both Congress and the current administration to turn aside principles of federalism and separation of powers in order to promote a "culture of life."

The body of legislation regarding the right to die, which covers a period of greater than 30 years, demonstrates how law evolves with changing technology and changing cultural beliefs. It highlights the challenges of creating law within the framework of the Constitution, written over two hundred years ago by authors who undoubtedly could not imagine the scenarios to which it is currently applied. The legal debate regarding the right to die exemplifies the constant tension that exists at the outer reaches where new law is being made.

Although the nation remains divided on this controversial issue, we must continue to strive to create law that honors our constitutional rights and reflects our shared humanity.